OLR Bill Analysis

sHB 6612

AN ACT CONCERNING THE HEALTH INSURANCE GRIEVANCE PROCESS FOR ADVERSE DETERMINATIONS, THE OFFICE OF THE HEALTHCARE ADVOCATE AND MENTAL HEALTH PARITY COMPLIANCE CHECKS.

SUMMARY:

This bill makes various changes to the health insurance grievance process for adverse determinations (e.g., claims denials). It treats requests for certain services or treatments for mental or substance use disorders as urgent care requests. As a result, it reduces the time insurers or other health carriers have to (1) make initial determinations on claims for these services and treatments and (2) act on requests to review adverse determinations. It specifies the clinical review criteria that must be used in any benefit determination or utilization review regarding the treatment or provision of services for such disorders.

Under current law, a person acting on behalf of an insurer must apply a prudent layperson's judgment to determine whether a benefit request should be considered urgent. But if the request is from a health care professional who (1) knows the condition of a covered person (e.g., an insured) and (2) deems the request to be urgent, it must be treated as such. Starting July 1, 2014, the bill eliminates the prudent layperson standard and deems as urgent those (1) judged urgent by the health care professional or (2) dealing with the specified services for mental or substance use disorders.

The bill expands the notice that carriers must provide a covered person and his or her authorized representative when the carrier makes an adverse determination or upholds this determination after review. For some non-urgent care requests, it requires that a treatment be continued without liability to the covered person while an adverse determination is appealed, as is already the case with urgent requests.

By law, carriers must contract with clinical peers to evaluate the clinical appropriateness of adverse determinations. The bill additionally requires that clinical peers review all adverse determinations based at least in part on medical necessity, rather than just those involving utilization review. It requires clinical peers to have additional qualifications.

The bill expands the (1) role of the Office of the Healthcare Advocate (OHA) and (2) applicability of the requirement that employers post a notice concerning OHA.

By law, the insurance commissioner must prepare an annual consumer report card that, among other things, addresses managed care organizations and mental health services. The bill requires the commissioner to annually analyze this data for the accuracy of, trends in, and statistically significant differences in the data among the health care centers and health insurers included in the report card. It requires him to investigate such differences to determine whether he should take further action.

Additionally, the bill requires:

1. the Insurance Commissioner, by September 1, 2013, to report to the Insurance and Public Health committees on how the Insurance Department will check the compliance with state and federal mental health insurance parity laws;

2. the commissioner to begin the compliance checks using the selected method by October 1, 2013; and

3. the department's annual report to the Insurance and Public Health committees to summarize the method it uses to check for compliance and the results of the compliance checks.

Lastly, the bill makes minor and technical changes.

EFFECTIVE DATE: Upon passage for the commissioner's compliance report; October 1, 2013 for the provisions on mental and substance use disorders, adverse determination notices, and the OHA;

and July 1, 2014 for the provisions dealing with clinical peers, utilization reviews, and the prudent layperson standard.

REQUEST FOR MENTAL OR SUBSTANCE USE DISORDER SERVICES

Benefit Determination

By law, the amount of time a carrier has to make a benefit determination depends on whether or not it is an urgent request. In general, carriers must make a determination with 15 calendar days for non-urgent requests but within 72 hours for urgent requests.

The bill treats as urgent requests, those for a service or treatment for (1) substance use disorder or co-occurring mental disorder and (2) inpatient services, partial hospitalization, or intensive outpatient services needed to keep a covered person from requiring in inpatient setting in connection with a mental disorder.

It requires the carrier to make its determination as soon as possible, but no more than 24 hours after it receives a request for service or treatment for these disorders. If the request is to extend a course of treatment beyond the initial period or number of treatments, the request must be made at least 24 hours before the initial authorization runs out. The 24-hour deadline for the carrier does not apply if the covered person or his or her representative fails to provide the information the carrier needs to make its determination.

Expedited Reviews

By classifying requests for these services and treatments as urgent, the bill entitles the covered person to an expedited review of an adverse determination. Under current law, the carrier or independent review organization must notify the covered person and his or her representative of its decision regarding an expedited review within 72 hours of receiving a grievance. The bill requires that carriers make their decision for expedited reviews of requests for services and treatment for the mental and substance use disorders within 24 hours.

Utilization Review

By law, each carrier must contract with health care professionals to administer its utilization review program. Utilization review is the use of formal techniques to monitor the use of health care services or evaluate their medical necessity, appropriateness, efficacy, or efficiency.

Under current law, each program must use documented clinical review criteria based on sound clinical evidence. The bill requires that, for any utilization review or benefit determination for treating a substance use disorder, the program use the following criteria:

1. the most recent edition of the American Society of Addiction Medicine's Patient Placement Criteria or

2. clinical review criteria that are developed as required under state law and reviewed and accepted by the Department of Mental Health and Addiction Services (DMHAS) for adults and the Department of Children and Families (DCF) for children and adolescents, as adhering to the prevailing standard of care.

A carrier that uses criteria developed pursuant to state law must create and maintain a document that:

1. compares each aspect of these criteria with the society's patient placement criteria and

2. provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from those criteria.

For any utilization review or benefit determination for treating a mental disorder, the criteria must be:

1. for children and adolescents, the most recent guidelines in the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument or

2. clinical review criteria that are developed as required under

state law, and reviewed and accepted by DMHAS or DCF as applicable, as adhering to the prevailing standard of care.

A carrier that uses criteria developed pursuant to state law for children and adolescents must create and maintain a document that

1. compares each aspect of the criteria with the guidelines in the academy's instrument and

2. provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the guidelines in this instrument.

ADVERSE DETERMINATIONS

Initial Adverse Determination Notices

By law, each carrier must promptly notify a covered person and, if applicable, his or her authorized representative, of an adverse determination. The bill additionally requires the notice to list, upon request, any clinical review criteria (including professional criteria) and medical or scientific evidence used to reach a denial.

By law, the notice must describe the carrier's internal grievance procedures. Under current law, this description must state that the covered person or his or her representative can submit written comments, documents, records, and other material regarding the request for the individuals conducting the review. The bill instead requires the notice to include a statement that, if the covered person or his or her representative chooses to grieve an adverse determination, that:

1. such appeals sometimes succeed;

2. the covered person or his or her representative may benefit from free assistance from OHA, which can help with a grievance;

3. the covered person or representative is entitled and encouraged

to submit supporting documentation for the carrier to consider during the review of an adverse determination, including their narratives describing the problem, when the problem arose, the symptoms, and letters and treatment notes from the covered person's health care professional; and

4. the covered person or his or her representative has the right to ask his or her health care professional for these letters and treatment notes.

Reviews

By law, the covered person or his or her representative can grieve an adverse determination. Under the bill, if the decision in a review of a case that is not based on medical necessity upholds the adverse determination, the notice of the decision must include a statement disclosing:

1. the covered person's right to contact the insurance commissioner's office or OHA at any time,

2. that the covered person may benefit from free assistance from OHA, which can help him or her file a grievance, and

3. the contact information for the offices.

Continuing Treatment While Determination Is Appealed

Under the bill, if a non-urgent request is a concurrent review request, as defined by federal law (i.e., one that takes place when the service is being requested), the treatment must be continued without liability to the covered person during the review or any grievance filed by a covered person or his or her representative of an adverse determination or a final adverse determination of the concurrent review. Existing law has a similar requirement in the case of urgent requests.

Clinical Peers

By law, carriers must contract with clinical peers to evaluate the clinical appropriateness of adverse determinations. The bill

additionally requires that clinical peers be used to review all adverse determinations based at least in part on medical necessity.

The bill requires that carriers contract with clinical peers to conduct utilization reviews, rather than requiring them to contract with health care professionals to oversee the determinations in these reviews. It requires the clinical peers to participate in various stages of the review process.

The bill requires certain clinical peers to have additional qualifications. Under current law, clinical peers are health care professionals who hold a non-restricted license in any state in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

For a review or benefit determination concerning a substance use disorder treatment or mental disorder in a child or adolescent, the clinical peer must (1) hold a national board certification in child and adolescent psychiatry or child and adolescent psychology and (2) have training or clinical experience in treating child and adolescent substance use or mental disorder, as applicable.

The bill requires that each carrier have procedures to ensure that the appropriate or required clinical peers are designated to conduct utilization reviews.

The bill eliminates the requirement that, in order to be approved by the commissioner, an independent organization that reviews adverse determinations must assign as a clinical peer a health care professional who:

1. is an expert treating the covered person's medical condition that is the subject of the review;

2. is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person; and

3. holds a nonrestricted license in a state and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.

The changes in the qualifications for clinical peers described above apply to the clinical peers assigned by these organizations.

OFFICE OF THE HEALTH CARE ADVOCATE

Role

The bill expands the role of OHA by expanding the definition of "consumer," "managed care organization," and "managed care plan."

By law, OHA can assume a wide range of responsibilities regarding the plans that managed care organizations provide to consumers. These include:

1. helping consumers select managed care plans and understand their rights and responsibilities under them,

2. helping consumers file appeals with managed care organizations, and

3. pursuing administrative remedies on behalf of consumers.

The bill expands the definition of:

1. "consumer" to include his or her authorized representative,

2. "managed care plan" to include policies or plans that cover all types of health insurance regulated by the Insurance Department,

3. "managed care organization" to include organizations that continue individual or group managed care plans (the law already covers organizations that deliver, renew, or amend such plans).

Employer Notices

The bill applies the requirement that employers post a notice concerning the services OHA provides to (1) self-insured employers and (2) all employers that provide health care benefits to their employees. By law, employers that provide health insurance to their employees must post such notices.

REPORTS ON MENTAL HEALTH PARITY AND COMPLIANCE CHECKS

By September 1, 2013, the bill requires the insurance commissioner to report to the Insurance and Public Health committees on the method the Insurance Department will use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction. In selecting the method, the commissioner must (1) examine the methods developed by the U.S. Department of Labor and URAC (an accreditor of health care organizations) and other methods discovered by or brought to the department's attention and (2) determine how well they work.

As part of the evaluation process, the commissioner must hold at least one public meeting where stakeholders can share their input and propose other compliance check methods. The stakeholders must at least include relevant state agency personnel, health insurance companies, and the general public.

The report must describe and address the comments shared at the meetings, assess each potential method examined, and append written comments and suggestions of the Healthcare Advocate.

By October 1, 2013, the commissioner must begin the compliance checks using the selected method.

The bill also requires that the department's annual report to the Insurance and Public Health committees include (1) a summary of the method the department uses to check for compliance with state and federal mental health parity laws and (2) results of these checks.

BACKGROUND

Related Bills

SB 599, favorably reported by the Insurance and Real Estate Committee (file number 5), requires health insurers to authorize an insured's pharmacy to fill a prescription if the insured or his or her authorized representative files a grievance or requests a review of an adverse determination or final adverse determination related to dispensing a drug prescribed by a licensed participating provider.

HB 6517, favorably reported by the Program Review and Investigations Committee, among other things includes the same mental health compliance check provisions as in this bill. It also requires the Insurance Department to request the U.S. Department of Health and Human Services to rule on whether external appeal applicants must provide either an adverse determination notice, an insurance identification card, or both, and act accordingly in response.

HB 6557, favorably reported by the Program Review and Investigations Committee, has a number of provisions that are similar or identical to those in this bill. Among other things, it (1) treats as urgent, requests for treatments of substance use co-occurring disorders, (2) generally requires carriers to make determinations for urgent care requests for inpatient substance use disorder treatment within 24 hours, and (3) expands notice requirements for carriers making an adverse determination. HB 6557 also establishes additional qualification requirements for clinical peers who review adverse determinations.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 0 (03/19/2013)